

Billing Workshop Audiology

Colorado Medicaid
2015



COLORADO

Department of Health Care
Policy & Financing



Centers for
Medicare &
Medicaid
Services



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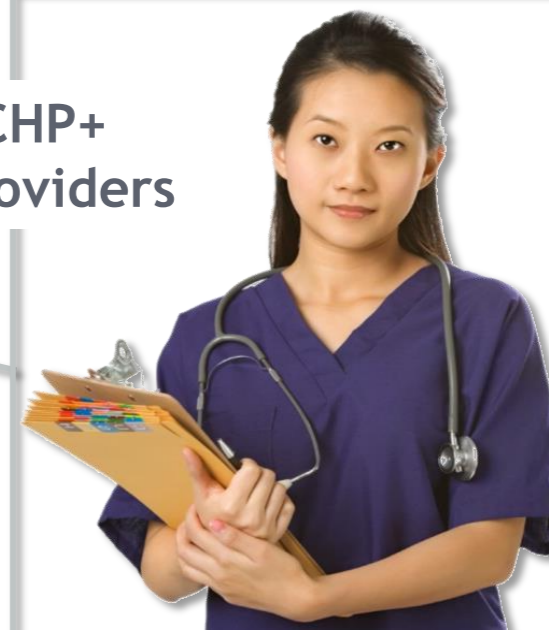


Medicaid



Xerox State
Healthcare

Medicaid/CHP+
Medical Providers



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Training Objectives

- Billing Pre-Requisites
 - National Provider Identifier (NPI)
 - What it is and how to obtain one
 - Eligibility
 - How to verify
 - Know the different types
- Billing Basics
 - How to ensure your claims are timely
 - When to use the CMS 1500 paper claim form
 - How to bill when other payers are involved



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What is an NPI?

- National Provider Identifier
- Unique 10-digit identification number issued to U.S. health care providers by CMS
- All HIPAA covered health care providers/organizations must use NPI in all billing transactions
- Are permanent once assigned
 - Regardless of job/location changes



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What is an NPI? (cont.)

- How to Obtain & Learn Additional Information:
 - CMS web page (paper copy)-
 - www.dms.hhs.gov/nationalproidentstand/
 - National Plan and Provider Enumeration System (NPPES)-
 - www.nppes.cms.hhs.gov
 - Enumerator-
 - 1-800-456-3203
 - 1-800-692-2326 TTY



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Department Website

The screenshot shows the website <https://www.colorado.gov/hcpf>. A purple circle with the number '1' and an arrow points to the address bar. Another purple circle with the number '2' and an arrow points to the 'For Our Providers' link in the navigation menu. The website header includes the Colorado state logo and the text 'Colorado The Official Web Portal'. The main content area features a navigation bar with links: Home, For Our Members, For Our Providers, and For Our Stakeholders. Below the navigation bar, a banner states: 'We administer Medicaid, Child Health Plan Plus, and other health care programs for Coloradans who qualify.' The main content area is divided into four columns: 'Explore Benefits' (with a magnifying glass icon), 'Apply Now' (with a checkmark icon), 'Find Doctors' (with a group of people icon), and 'Get Help' (with an information icon). At the bottom, there are two promotional boxes: 'Feeling Sick?' with a nurse icon and the text 'For medical advice, call the Nurse Line: 800-283-3221', and 'Get Covered. Stay Healthy.' with an umbrella icon and the text 'colorado.gov/health'.

1

www.colorado.gov/hcpf

2

For Our Providers



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Provider Home Page

Find what
you need
here

Contains important
information
regarding Colorado
Medicaid & other
topics of interest to
providers & billing
professionals



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Provider Enrollment

Question:

What does Provider Enrollment do?

Answer:

Enrolls **providers** into the Colorado Medical Assistance Program, not members

Question:

Who needs to enroll?

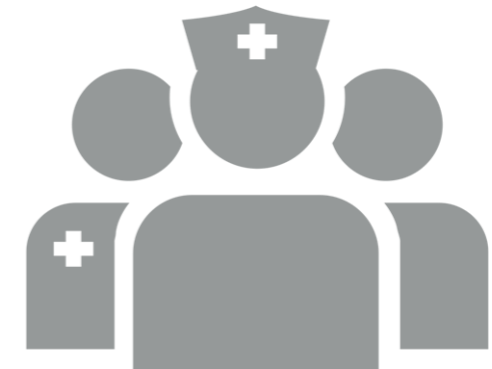
Answer:

Everyone who provides services for Medical Assistance Program members

Rendering Versus Billing

Rendering Provider

Individual that provides services to a Medicaid member



Billing Provider

Entity being reimbursed for service



Verifying Eligibility

- Always print & save copy of eligibility verifications
- Keep eligibility information in member's file for auditing purposes
- Ways to verify eligibility:



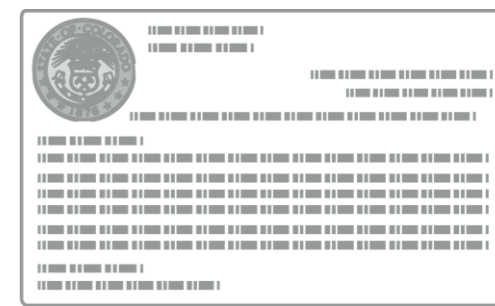
**Colorado Medical
Assistance Web Portal**



**Fax Back
1-800-493-0920**



**CMERS/AVRS
1-800-237-0757**



**Medicaid ID Card
with Switch Vendor**

Eligibility Response Information

Eligibility
Dates

Co-Pay
Information

Third Party
Liability
(TPL)

Prepaid
Health Plan

Medicare

Special
Eligibility

BHO

Guarantee
Number

Eligibility Request Response (271)

[Print](#)[Return To Eligibility Inquiry](#)

Eligibility Request

Provider ID: National Pro

From DOS: Through D

Client Detail

State ID: DOB:

Last Name: First Name

CO MEDICAL ASSISTANCE

Response Creation Date & Time: 05/19/20

Contact Information for Questions on Res

Provider Relations Number: 800-237-075

Requesting Provider

Provider ID:

Name:

Client Details

Name:

State ID:

Client Eligibility Details

Eligibility Status: **Eligible**

Eligibility Benefit Date: 04/06/2011 - 04/06/2011

Guarantee Number: **111400000000**

Coverage Name: Medicaid

PREPAID HEALTH PLAN OR ACCOUNTABLE CARE COLLABORATIVE

Eligibility Benefit Date: 04/06/2011 - 04/06/2011

Messages:

MHPROV Services

Provider Name:

COLORADO HEALTH PARTNERSHIPS LLC

Provider Contact Phone Number: 800-804-5008

Information appears in sections:

- Requesting Provider, Member Details, Member Eligibility Details, etc.
- Use scroll bar on right to view details

Successful inquiry notes a Guarantee Number:

- Print copy of response for member's file when necessary

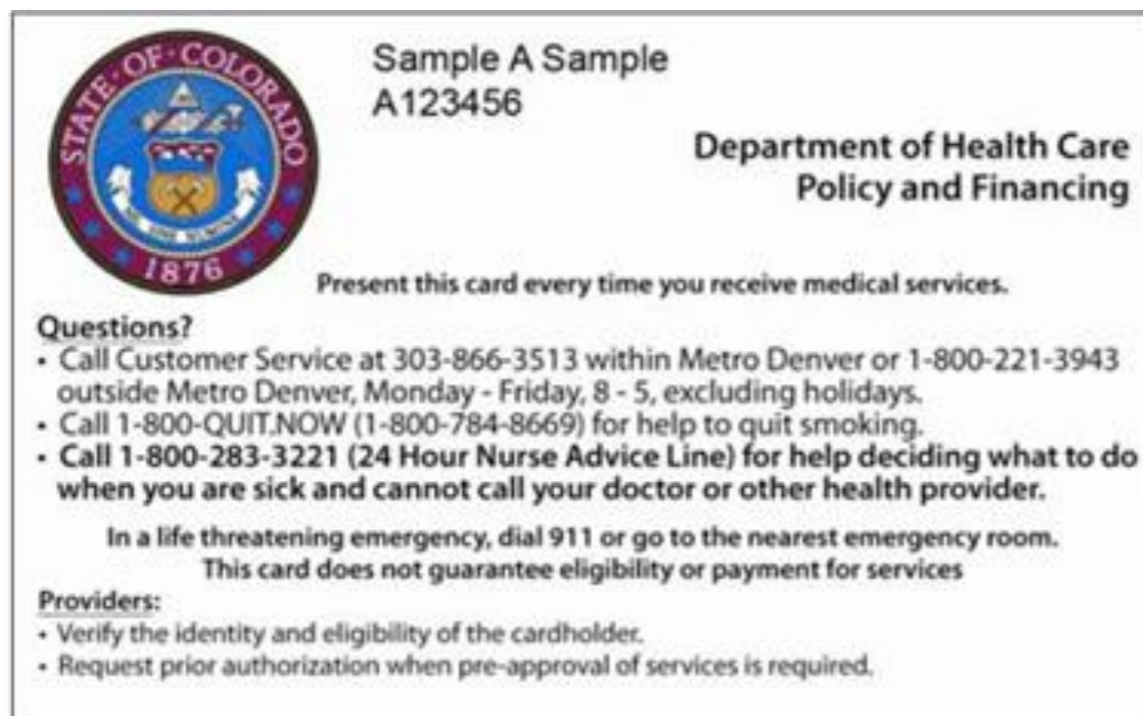
Reminder:

- Information received is based on what is available through the Colorado Benefits Management System (CBMS)
- Updates may take up to 72 hours



Medicaid Identification Cards

- Both cards are valid
- Identification Card does not guarantee eligibility



Eligibility Types

- Most members = Regular Colorado Medicaid benefits
- Some members = different eligibility type
 - Modified Medical Programs
 - Non-Citizens
 - Presumptive Eligibility
- Some members = additional benefits
 - Managed Care
 - Medicare
 - Third Party Insurance

Eligibility Types

Modified Medical Programs

- Members are not eligible for regular benefits due to income
- Some Colorado Medical Assistance Program payments are reduced
- Providers cannot bill the member for the amount not covered
- Maximum member co-pay for OAP-State is \$300
- Does not cover:
 - Long term care services
 - Home and Community Based Services (HCBS)
 - Inpatient, psych or nursing facility services

Eligibility Types

Non-Citizens

- Only covered for admit types:
 - Emergency = 1
 - Trauma = 5
- Emergency services (must be certified in writing by provider)
 - Member health in serious jeopardy
 - Seriously impaired bodily function
 - Labor / Delivery
- Member may not receive medical identification care before services are rendered
- Member must submit statement to county case worker
- County enrolls member for the time of the emergency service only

What Defines an “Emergency”?

- Sudden, urgent, usually unexpected occurrence or occasion requiring immediate action such that of:
 - Active labor & delivery
 - Acute symptoms of sufficient severity & severe pain in which, the absence of immediate medical attention might result in:
 - Placing health in serious jeopardy
 - Serious impairment to bodily functions
 - Dysfunction of any bodily organ or part

Eligibility Types

Presumptive Eligibility

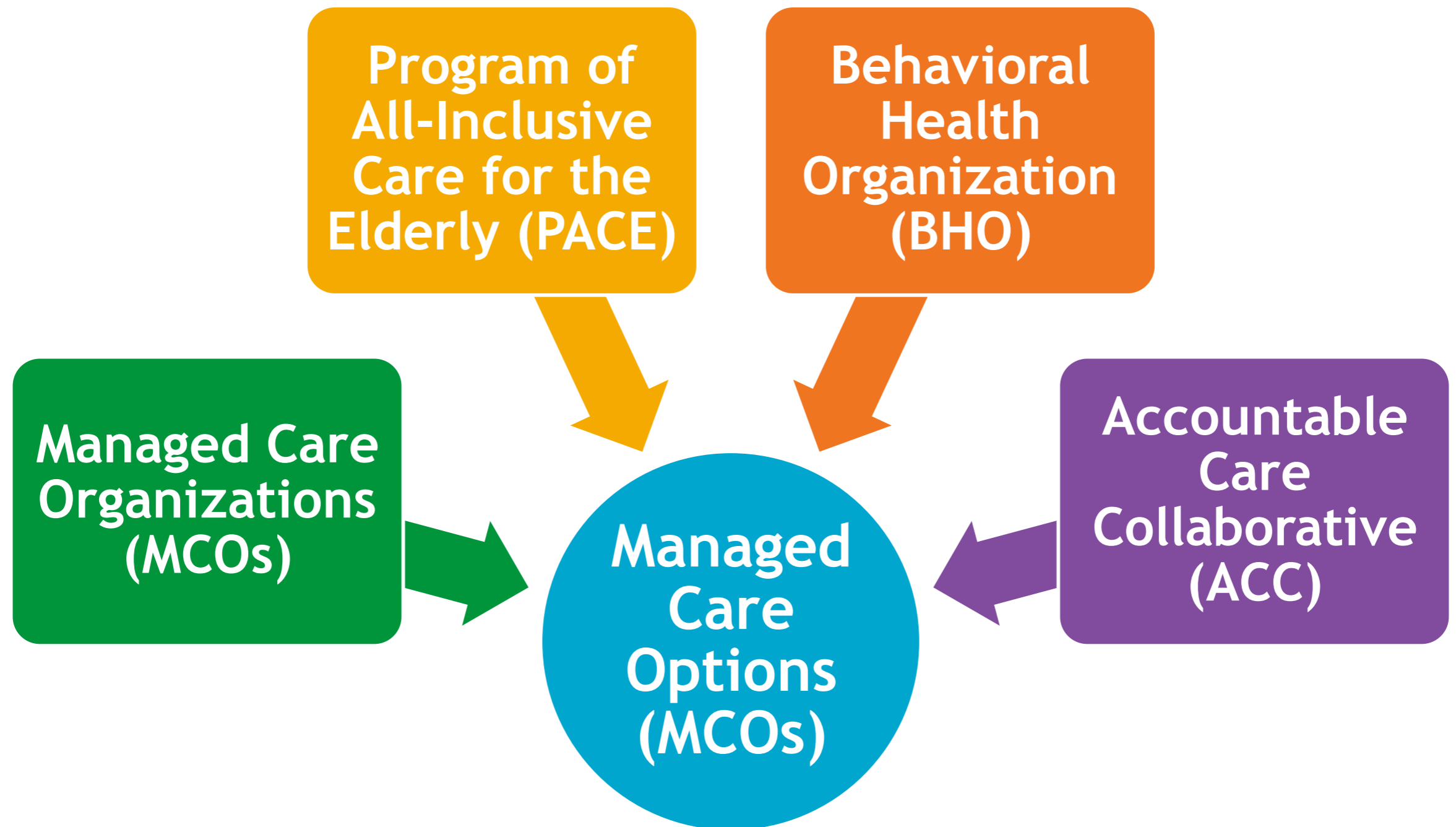
- Temporary coverage of Colorado Medicaid or CHP+ services until eligibility is determined
 - Member eligibility may take up to 72 hours before available
- Medicaid Presumptive Eligibility is only available to:
 - Pregnant women
 - Covers DME and other outpatient services
 - Children ages 18 and under
 - Covers all Medicaid covered services
 - Labor / Delivery
- CHP+ Presumptive Eligibility
 - Covers all CHP+ covered services, except dental

Eligibility Types

Presumptive Eligibility (cont.)

- Verify Medicaid Presumptive Eligibility through:
 - Web Portal
 - Faxback
 - CMERS
 - May take up to 72 hours before available
- Medicaid Presumptive Eligibility claims
 - Submit to the Fiscal Agent
 - Xerox Provider Services- 1-800-237-0757
- CHP+ Presumptive Eligibility and claims
 - Colorado Access- 1-888-214-1101

Managed Care Options



Managed Care Options

Managed Care Organization (MCO)

- Eligible for Fee-for-Service if:
 - MCO benefits exhausted
 - Bill on paper with copy of MCO denial
 - Service is not a benefit of the MCO
 - Bill directly to the fiscal agent
 - MCO not displayed on the eligibility verification
 - Bill on paper with copy of the eligibility print-out

Managed Care Options

Behavioral Health Organization (BHO)

- Community Mental Health Services Program
 - State divided into 5 service areas
 - Each area managed by a specific BHO
 - Colorado Medical Assistance Program Providers
 - Contact BHO in your area to become a Mental Health Program Provider



Managed Care Options

Accountable Care Collaborative (ACC)

- Connects Medicaid members to:
 - Regional Care Collaborative Organization (RCCO)
 - Medicaid Providers
 - Connects Medicaid members to:
- Helps coordinate Member care
 - Helps with care transitions

Medicare

- Medicare members may have:
 - Part A only- covers Institutional Services
 - Hospital Insurance
 - Part B only- covers Professional Services
 - Medical Insurance
 - Part A and B- covers both services
 - Part D- covers Prescription Drugs

Medicare

Qualified Medicare Beneficiary (QMB)

- Bill like any other TPL
- Members only pay Medicaid co-pay
- Covers any service covered by Medicare
 - QMB Medicaid- members also receive Medicaid benefits
 - QMB Only- members do not receive Medicaid benefits
 - Pays only coinsurance and deductibles of a Medicare paid claim

Medicare

Medicare-Medicaid Enrollees

- Eligible for both Medicare & Medicaid
- Formerly known as “Dual Eligible”
- Medicaid is always payer of last resort
 - Bill Medicare first for Medicare-Medicaid Enrollee members
- Retain proof of:
 - Submission to Medicare prior to Colorado Medical Assistance Program
 - Medicare denials(s) for six years

Third Party Liability

- Colorado Medicaid pays Lower of Pricing (LOP)

- Example:

- Charge = \$500
- Program allowable = \$400
- TPL payment = \$300
- Program allowable - TPL payment = LOP

$$\begin{array}{r} \$400.00 \\ - \$300.00 \\ = \$100.00 \end{array}$$

Commercial Insurance

- Colorado Medicaid always payer of last resort
- Indicate insurance on claim
- Provider cannot:
 - Bill member difference or commercial co-payments
 - Place lien against members right to recover
 - Bill at-fault party's insurance

Co-Payment Exempt Members



**Nursing Facility
Residents**



Children



**Pregnant
Women**

Co-Payment Facts

- Auto-deducted during claims processing
 - Do not deduct from charges billed on claim
- A provider may not deny services to an individual when such members are unable to immediately pay the co-payment amount. However, the member remains liable for the co-payment at a later date. (8.754.6.B rule in 10 CCR 2505 volume 8.700)
- Services that do not require co-pay:
 - Dental
 - Home Health
 - HCBS
 - Transportation
 - Emergency Services
 - Family Planning Services

Specialty Co-payments

Audiologist

\$2.00 per date of service

Billing Overview

Record
Retention

Claim
submission

Prior
Authorization
Requests
(PARs)

Timely filing

Extensions for
timely filing

Record Retention

- Providers must:
 - Maintain records for at least 6 years
 - Longer if required by:
 - Regulation
 - Specific contract between provider & Colorado Medical Assistance Program
 - Furnish information upon request about payments claimed for Colorado Medical Assistance Program services

Record Retention

- Medical records must:
 - Substantiate submitted claim information
 - Be signed & dated by person ordering & providing the service
 - Computerized signatures & dates may be used if electronic record keeping system meets Colorado Medical Assistance Program security requirements

Submitting Claims

- Methods to submit:
 - Electronically through Web Portal
 - Electronically using Batch Vendor, Clearinghouse, or Billing Agent
 - Paper only when:
 - Pre-approved (consistently submits less than 5 per month)
 - Claims require attachments

ICD-10 Implementation Delay

ICD-10 Implementation delayed until 10/1/2015

Claims with Dates of Service (DOS) on or before 9/30/15

Use ICD-9 codes

Claims with Dates of Service (DOS) on or after 10/1/2015

Use ICD-10 codes

Claims submitted with both ICD-9 and ICD-10 codes

Will be rejected

Providers Not Enrolled with EDI



COLORADO MEDICAL ASSISTANCE PROGRAM

Provider EDI Enrollment Application

Colorado Medical Assistance Program
PO Box 1100
Denver, Colorado 80201-1100
1-800-237-0757
colorado.gov/hcpf

Providers must be enrolled with EDI to:

- use the Web Portal
- submit HIPAA compliant claims
- make inquiries
- retrieve reports electronically
 - Select Provider Application for EDI Enrollment

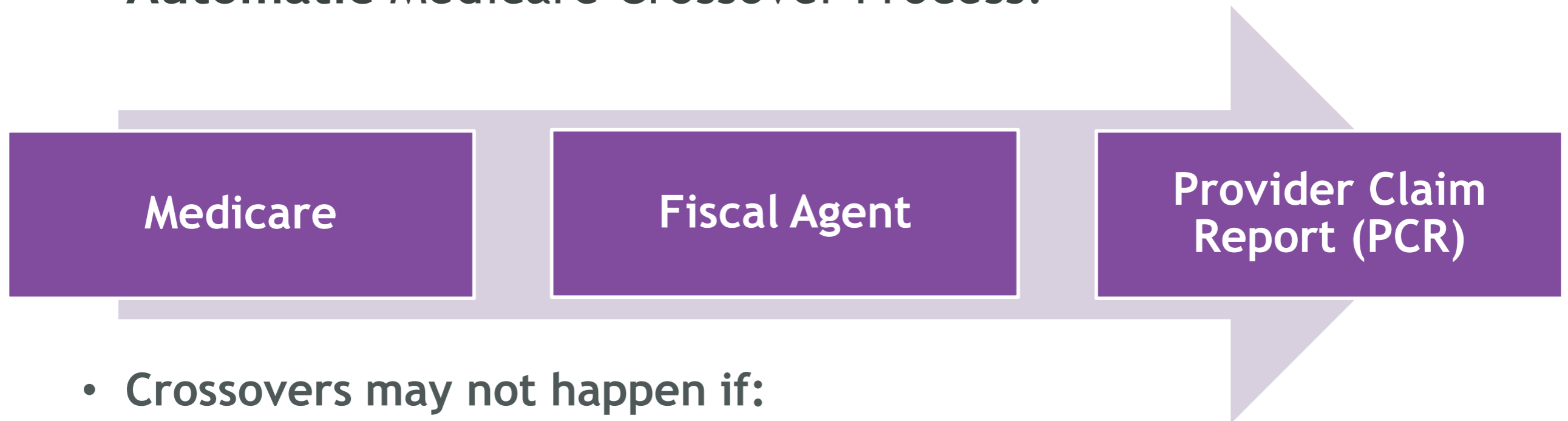
Colorado.gov/hcpf/EDI-Support



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Crossover Claims

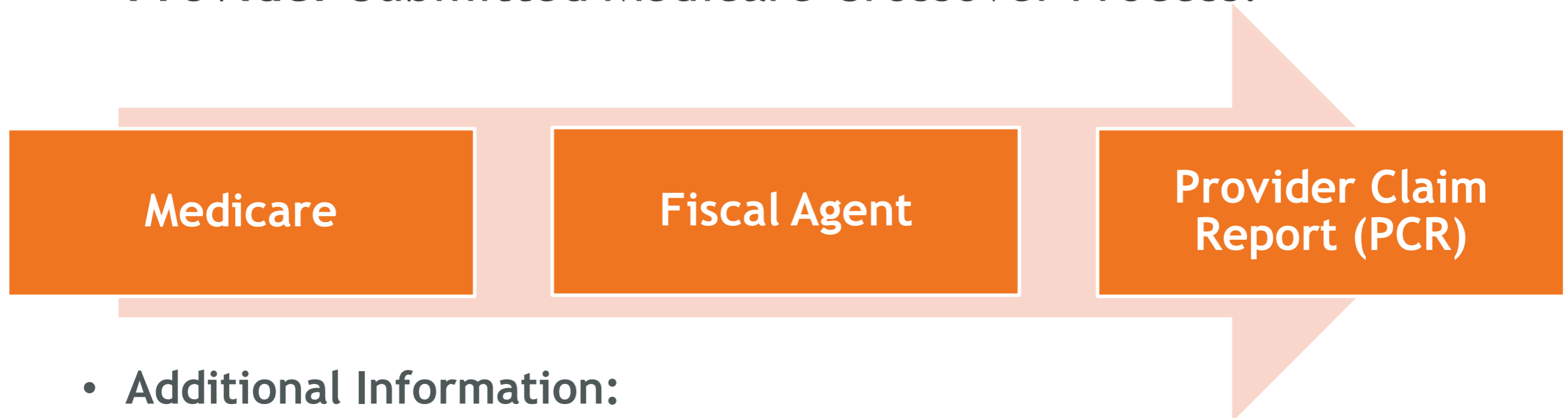
Automatic Medicare Crossover Process:



- Crossovers may not happen if:
 - NPI not linked
 - Member is a retired railroad employee
 - Member has incorrect Medicare number on file

Crossover Claims

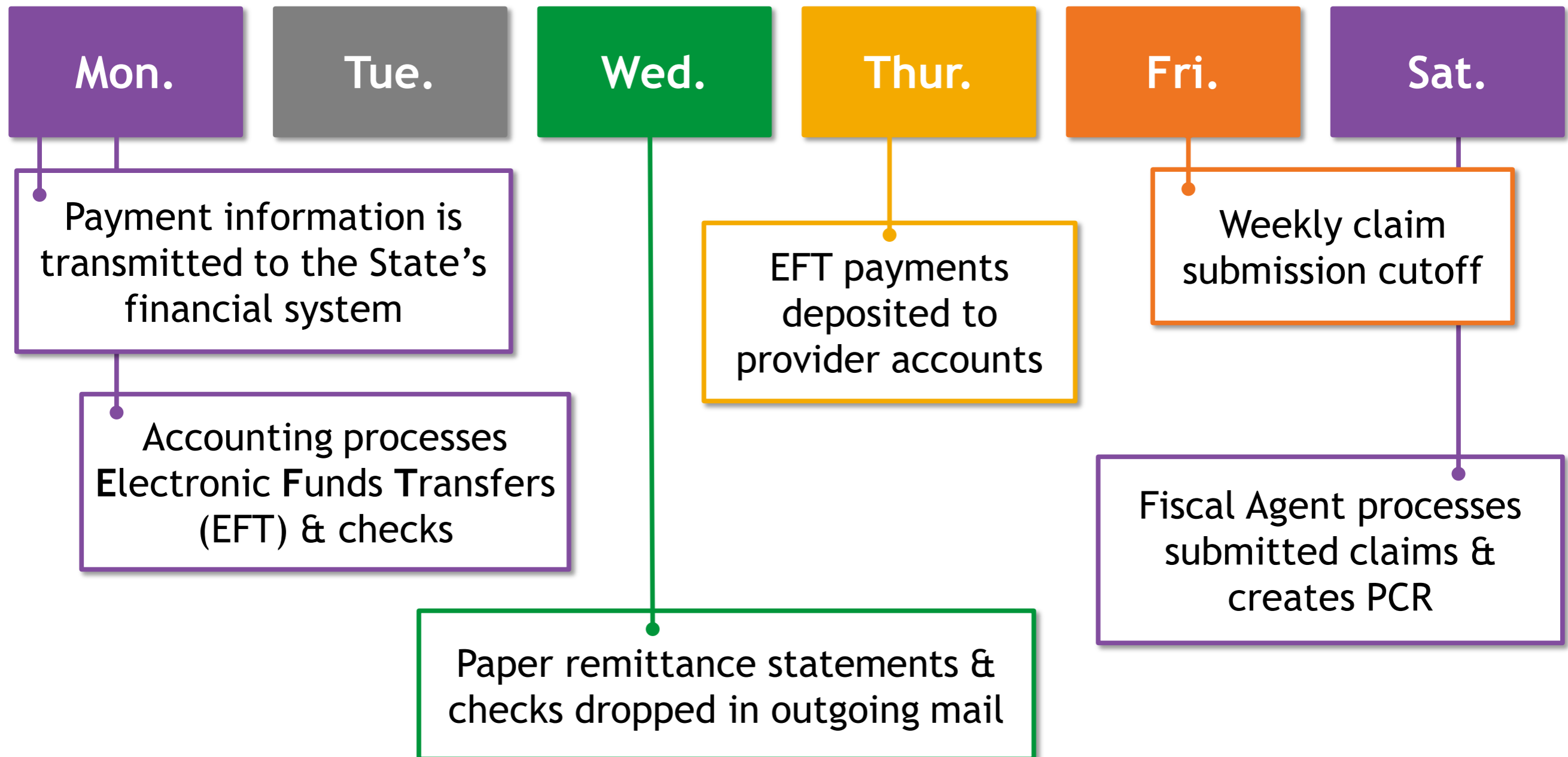
Provider Submitted Medicare Crossover Process:



- **Additional Information:**

- Submit claim yourself if Medicare crossover claim not on PCR within 30 days
- Crossovers may be submitted on paper or electronically
- Provider must submit copy of SPR with paper claims
- Provider must retain SPR for audit purposes

Payment Processing Schedule



Electronic Funds Transfer (EFT)

Advantages

Free!

No postal service delays

Automatic deposits every Thursday

Safest, fastest & easiest way to receive payments

[Colorado.gov/hcpf/provider-forms](https://colorado.gov/hcpf/provider-forms) → Other Forms

PARs Reviewed by ColoradoPAR

- With the exception of Waiver and Nursing Facilities:
 - The ColoradoPAR Program processes all PARs
 - including revisions
 - Visit ColoradoPAR.com for more information

Mail:

Prior Authorization Request
55 N Robinson Ave., Suite 600
Oklahoma City, OK 73102

Phone:

Phone: 1.888.454.7686
FAX: 1.866.492.3176
Web: ColoradoPAR.com

Electronic PAR Information

- PARs/revisions processed by the ColoradoPAR Program must be submitted via CareWebQI (CWQI)
- The ColoradoPAR Program will process PARs submitted by phone for:
 - emergent out-of-state
 - out-of area inpatient stays
 - e.g. where the patient is not in their home community and is seeking care with a specialist, and requires an authorization due to location constraints

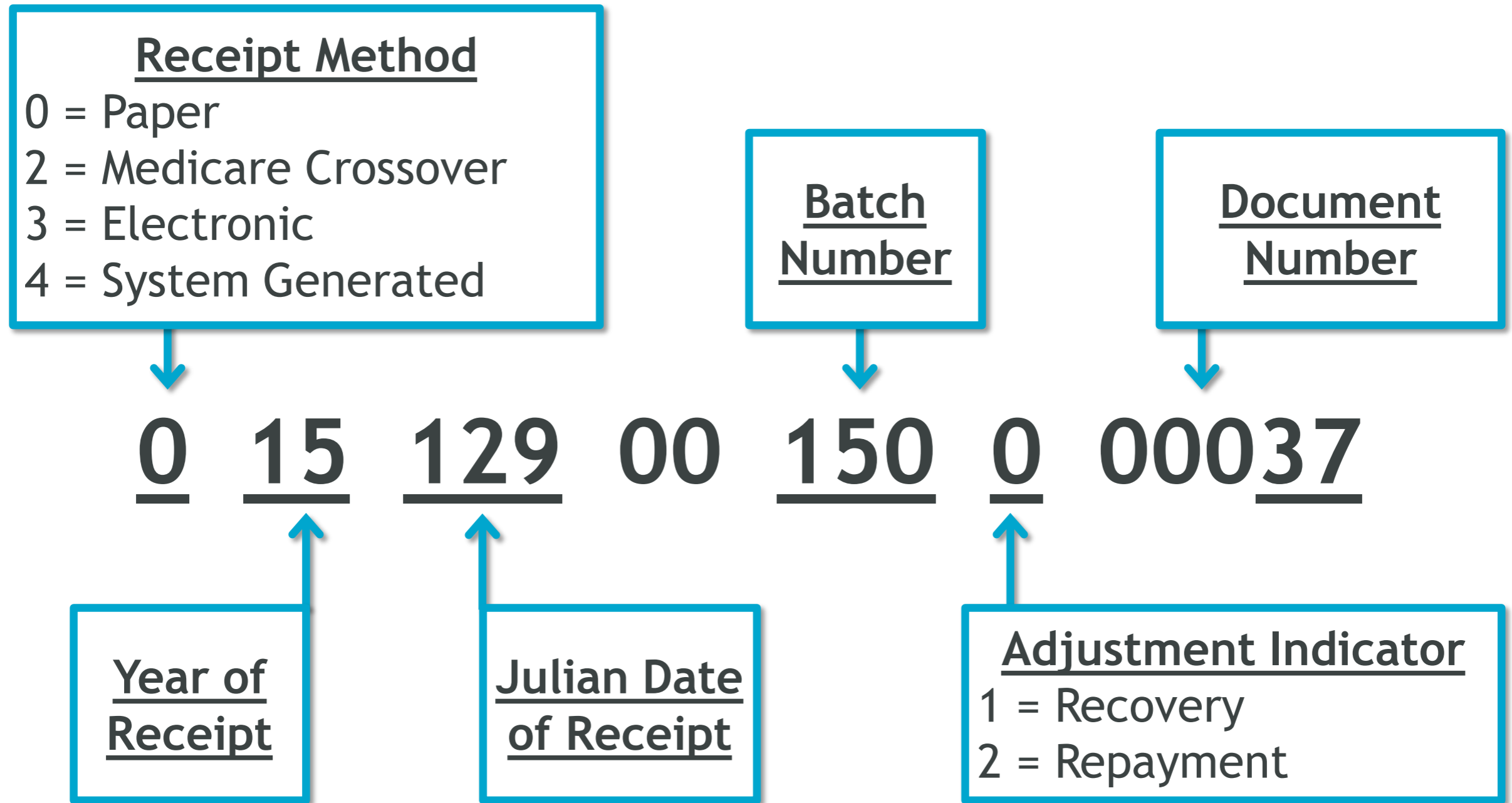
PAR Letters/Inquiries

- Continue utilizing Web Portal for PAR letter retrieval/PAR status inquiries
- PAR number on PAR letter is only number accepted when submitting claims
- If a PAR Inquiry is performed and you cannot retrieve the information:
 - contact the ColoradoPAR Program
 - ensure you have the right PAR type
 - e.g. Medical PAR may have been requested but processed as a Supply PAR

PAR Letters

- Xerox generates PAR Letters daily
 - If a billing provider sends a request one a week/month, PAR letter will be generated once a week/month
- Who receives a PAR letter?
 - Billing Providers retrieve directly from the FRS
 - Requesting Provider and Member receives by mail
- Letters are available for 60 days

Transaction Control Number



Timely Filing

- 120 days from Date of Service (DOS)
 - Determined by date of receipt, not postmark
 - PARs are not proof of timely filing
 - Certified mail is not proof of timely filing
 - Example - DOS January 1, 20XX:
 - Julian Date: 1
 - Add: 120
 - Julian Date = 121
 - Timely Filing = Day 121 (May 1st)

Timely Filing

From “through” DOS

- Nursing Facility
- Home Health
- Waiver
- In- & Outpatient
- UB-04 Services

From delivery date

- Obstetrical Services
- Professional Fees
- Global Procedure Codes:
- Service Date = Delivery Date

From DOS

FQHC Separately Billed and additional Services

Documentation for Timely Filing

- 60 days from date on:
 - Provider Claim Report (PCR) Denial
 - Rejected or Returned Claim
 - Use delay reason codes on 837P transaction
 - Keep supporting documentation
- Paper Claims
 - CMS 1500- Note the Late Bill Override Date (LBOD) and the date of the last adverse action in field 19 (Additional Claim Information)

Timely Filing

Medicare/Medicaid Enrollees

Medicare pays claim

120 days from Medicare
payment date

Medicare denies claim

60 days from Medicare
denial date

Timely Filing Extensions

- Extensions may be allowed when:
 - Commercial insurance has yet to pay/deny
 - Delayed member eligibility notification
 - Delayed Eligibility Notification Form
 - Backdated eligibility
 - Load letter from county

Timely Filing Extensions

Commercial Insurance

- 365 days from DOS
- 60 days from payment/denial date
- When nearing the 365 day cut-off:
 - File claim with Colorado Medicaid
 - Receive denial or rejection
 - Continue re-filing every 60 days until insurance information is available



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Timely Filing Extensions

Delayed Notification

- 60 days from eligibility notification date
 - Certification & Request for Timely Filing Extension - Delayed Eligibility Notification Form
 - Located in Forms section
 - Complete & retain for record of LBOD
- Bill electronically
 - If paper claim required, submit with copy of Delayed Eligibility Notification Form
- Steps you can take:
 - Review past records
 - Request billing information from member

Timely Filing Extensions

Backdated Eligibility

- 120 days from date county enters eligibility into system
 - Report by obtaining State-authorized letter identifying:
 - County technician
 - Member name
 - Delayed or backdated
 - Date eligibility was updated



APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN (ID#) <input type="checkbox"/> FECA BENEFIT (ID#) <input type="checkbox"/> OTHER (ID#) <input type="checkbox"/>		1a. INSURED'S LD. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
4. CITY		4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
STATE		7. INSURED'S ADDRESS (No., Street)	
ZIP CODE		8. RESERVED FOR NUCC USE	
TELEPHONE (Include Area Code) ()		9. CITY	
10. IS PATIENT'S CONDITION RELATED TO:		11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO		a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>	
b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State)		b. OTHER CLAIM ID (Designated by NUCC)	
c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		c. INSURANCE PLAN NAME OR PROGRAM NAME	
10d. CLAIM CODES (Designated by NUCC)		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9c.</i>	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.			
SIGNED		SIGNED	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.		15. OTHER DATE MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		17a. 17b. 17c. 17d.	
18. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate to service line below (24E)		20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES	
A. B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO.	
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG		23. PRIOR AUTHORIZATION NUMBER	
D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) MODIFIER		E. DIAGNOSIS POINTER	
F. \$ CHARGES		G. DAYS OF SERVICE H. EPISODE NUMBER I. LD. QUAL. J. RENDERING PROVIDER ID. #	
25. FEDERAL TAX ID. NUMBER SSN EIN		26. PATIENT'S ACCOUNT NO.	
27. ACCEPT ASSIGNMENT? (For gov't, dismt., see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$	
29. AMOUNT PAID \$		30. Rsvd for NUCC Use	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)		32. SERVICE FACILITY LOCATION INFORMATION	
33. BILLING PROVIDER INFO & PH# ()			
SIGNED		DATE	

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)



CMS 1500

What Audiology services can be billed on the CMS 1500?

Follow-up
Newborn hearing
Testing

Cochlear Implants

Hearing Aids

Audiology Benefits

- Hearing benefits are limited to the minimum services required to meet the member's medical needs
 - See Volume 8.280.06
- Hearing aids for children ages 20 and under
- Softband hearing aids (bone anchored hearings aids) for children ages 20 and under
- Speech therapy, hearing exams, diagnostic testing, surgeries and related hospitalizations are regular benefits
- Services are generally limited by age
 - Members 20 years old and younger and adults part of the Supported Living Services (SLS) waiver
 - With exceptions of Cochlear Implants, which require prior authorization
- Reimbursement for newborn hearing screens is included in the hospital delivery payment
- Separate follow-up testing for a newborn that has failed initial screening is reimbursable to the practitioner

Audiology Benefits

- Non-Covered Benefits for Adults ages 21 and over:
 - Hearing aids and ear molds for the purpose of noise reduction and swimming and hearing aid insurance are not a benefit
 - Exams and evaluations are a benefit only when a concurrent medical condition exists
- For more information on audiology services refer to the Audiology Billing Manual at:
 - www.colorado.gov/hcpf/billing-manuals

Hearing Aids

- Trial Rental Period is included in the purchase reimbursement for the hearing aid(s)
 - Use the last day of the rental period as the date of service
- Hearing Aids may be replaced if:
 - They no fit
 - Have been lost or stolen
 - Are no longer medically appropriate for the child
- Hearing aids are expected to last three to five years
- Hearing aid batteries are a benefit
 - Only for members ages 20 and younger

Procedure Codes

- Hearing “packages” are no longer used
- Individual services may require prior authorization
 - See fee schedule
- Services must be submitted for payment using HCPCS and CPT codes
- Providers should bill their usual and customary charges
- Hearing aids cannot be billed as a pair
 - Each individual hearing aid must be billed on separate lines with appropriate left and right modifier
 - One unit per line maximum

Colorado Home Intervention Program (CHIP)

- Outreach service of the Early Education Department of the Colorado School for the Deaf and the Blind (CSDB)
- Provides services in the home to children:
 - From newborn to preschool
 - Who are deaf or hard of hearing
 - Newborns identified with a hearing loss diagnosed from an audiologist receive further assessment and therapy services
- Reimbursable Medicaid benefit
- CHIP has many participating providers, including:
 - Audiologists and speech and language pathologists
 - Teachers of the deaf and hard of hearing

Colorado Home Intervention Program (CHIP)

- Medicaid benefit services provided under this program
 - Do not require Prior Authorization
- Services providers must be Medicaid enrolled
- All provider enrollment and claims submission requirements apply
- Bill using procedure codes:
 - 96111, 96115, 99341, 92521, 92522, 92523, 92524, 96105 and V5011
- For more information:
 - Visit the CSDB Website: www.csdb.org
- For NCCI (National Correct Coding Initiative) edits on these codes:
 - www.Colorado.gov/pacific/hcpf/provider-implementations



Colorado Hearing Resource Regional Coordinators

- Sponsored by:
 - The Department of Public Health and Environment (CDPHE)
 - The Department of Education (DOE)
- Ten regional coordinators throughout the state
- Coordinators work with audiologists and families to match children with hearing loss to the appropriate CHIP therapist
- CO-Hear coordinators provide technical assistance for:
 - Hearing loss, amplification and language assessment
 - Family-centered intervention for professionals, agencies and families
- For more information, visit:
 - www.cohandandvoices.org/resources/coguide/11_cohears.htm



Health Care Program

- For children with special needs
- Audiology Regional Coordinators provide:
 - Consultation information
 - Technical assistance
 - Referral services to families of children with special health care needs
- For more information:
 - www.cdphe.state.co.us

Common Denial Reasons

Timely Filing

Claim was submitted more than 120 days without a LBOD

Duplicate Claim

A subsequent claim was submitted after a claim for the same service has already been paid

Bill Medicare or Other Insurance

Medicaid is always the “Payer of Last Resort” - Provider should bill all other appropriate carriers first

Common Denial Reasons

PAR not on file

No approved authorization on file for services that are being submitted

Total Charges invalid

Line item charges do not match the claim total

Claims Process - Common Terms



Reject

Claim has primary data edits - not accepted by claims processing system



Denied

Claim processed & denied by claims processing system



Accept

Claim accepted by claims processing system



Paid

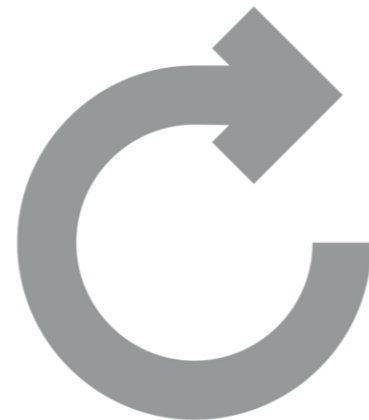
Claim processed & paid by claims processing system

Claims Process - Common Terms



Adjustment

Correcting
under/overpayments,
claims paid at zero &
claims history info



Rebill

Re-bill
previously
denied claim



Suspend

Claim must
be manually
reviewed before
adjudication



Void

“Cancelling” a
“paid” claim
(wait 48 hours
to rebill)

Adjusting Claims

- What is an adjustment?
 - Adjustments create a replacement claim
 - Two step process: Credit & Repayment

Adjust a claim when

- Provider billed incorrect services or charges
- Claim paid incorrectly

Do not adjust when

- Claim was denied
- Claim is in process
- Claim is suspended

Adjustment Methods



Web Portal

- Preferred method
- Easier to submit & track



Paper

- Complete field 22 on the CMS 1500 claim form

Provider Claim Reports (PCRs)

- Contains the following claims information:
 - Paid
 - Denied
 - Adjusted
 - Voided
 - In process
- Providers required to retrieve PCR through File & Report Service (FRS)
 - Via Web Portal

Provider Claim Reports (PCRs)

- Available through FRS for 60 days
- Two options to obtain duplicate PCRs:
 - Fiscal agent will send encrypted email with copy of PCR attached
 - \$2.00/ page
 - Fiscal agent will mail copy of PCR via FedEx
 - Flat rate- \$2.61/ page for business address
 - \$2.86/ page for residential address
- Charge is assessed regardless of whether request made within 1 month of PCR issue date or not

Provider Claim Reports (PCRs)

Paid

```

                                * CLAIMS PAID *
                                *****
INVOICE ----- CLIENT ----- TRANSACTION DATES OF SVC  TOTAL  ALLOWED  COPAY  AMT OTH  CLM PMT
NUM ----- NAME ----- STATE ID CONTROL NUMBER FROM TO  CHARGES  CHARGES  PAID  SOURCES  AMOUNT
7015          CLIENT, IMA      Z000000 04080000000000000001 040508 040508 132.00      69.46  2.00  0.00      69.46
PROC CODE - MODIFIER 99214 -                040508 040508 132.00      69.46  2.00
TOTALS - THIS PROVIDER / THIS CATEGORY OF SERVICE .... TOTAL CLAIMS PAID 1      TOTAL PAYMENTS      69.46

```

Denied

```

                                * CLAIMS DENIED *
                                *****
INVOICE ----- CLIENT ----- TRANSACTION DATES OF SERVICE  TOTAL ---- DENIAL REASONS ----
NUM ----- NAME ----- STATE ID CONTROL NUMBER FROM TO  DENIED ---- ERROR CODES ----
STEDOTCCIOT      CLIENT, IMA      A000000 30800000000000000003 03/05/08 03/06/08 245.04      1348
TOTAL CLAIMS DENIED - THIS PROVIDER / THIS CATEGORY OF SERVICE 1

```

THE FOLLOWING IS A DESCRIPTION OF THE DENIAL REASON (EXC) CODES THAT APPEAR ABOVE:

1348 The billing provider specified is not a fully active provider because they are enrolled in an active/non-billable status of '62', '63', '64', or '65' for the FDOS on the claim. These active/non-billable providers can't receive payment directly. The provider must be in a fully active enrollment status of '60' or '61'.

Provider Claim Reports (PCRs)

Adjustments

Recovery

***** * ADJUSTMENTS PAID * *****										
INVOICE --- CLIENT	-----	TRANSACTION	DATES OF SVC	ADJ	TOTAL	ALLOWED	COPAY	AMT OTH	CLM PMT	
NUM	NAME	STATE ID	CONTROL NUMBER	FROM	TO	RSN	CHARGES	CHARGES	PAID	SOURCES
Z71	CLIENT, IMA	A000000	40800000000100002	041008	041808	406	92.82-	92.82-	0.00	0.00
							92.82-			92.82-
							92.82-			
PROC CODE - MOD	T1019 - U1			041008	091808					
Z71	CLIENT, IMA	A000000	40800000000200002	041008	041808	406	114.24	114.24	0.00	0.00
							114.24			114.24
							114.24			
PROC CODE - MOD	T1019 - U1			041008	041808					
							114.24			
							114.24			
							NET IMPACT			21.42

Repayment

Net Impact

Voids

***** * ADJUSTMENTS PAID * *****										
INVOICE - CLIENT	-----	TRANSACTION	DATES OF SVC	ADJ	TOTAL	ALLOWED	COPAY	AMT OTH	CLM PMT	
NUM	NAME	STATE ID	CONTROL NUMBER	FROM	TO	RSN	CHARGES	CHARGES	PAID	SOURCES
A83	CLIENT, IMA	Y000002	40800000000100009	040608	042008	212	642.60-	642.60-	0.00	0.00
							642.60-			642.60-
							642.60-			
PROC CODE - MOD	T1019 - U1			040608	042008					
							642.60-			
							642.60-			
							NET IMPACT			642.60-

Provider Services

Xerox
1-800-237-0757

Claims/Billing/Payment

Forms/Website

EDI

Enrolling New Providers

Updating existing provider profile

CGI
1-888-538-4275

Email helpdesk.HCG.central.us@cgi.com

CMAP Web Portal technical support

CMAP Web Portal Password resets

CMAP Web Portal End User training

Thank you!



COLORADO

Department of Health Care
Policy & Financing